

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS61AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2010
NAME OF PROVIDER OR SUPPLIER MAYHILL MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3855 MAYHILL LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a follow-up survey conducted in your facility on 6/7/10 after a high level deficiency was identified in a previous survey. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was six. The following deficiencies were identified:	Y 000		
Y 991 SS=F	449.2756(1)(b) Alzheimer's Fac door alarm NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. This Regulation is not met as evidenced by: Based on observation and interview on 6/7/10, the facility failed to ensure doors alarms were operational for the protection of Alzheimer's	Y 991		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 991	<p>Continued From page 1</p> <p>residents.</p> <p>Findings include:</p> <p>On 06/07/10 at 11:00 AM, it was observed 2 of 4 exit doors had their alarms disabled. The front entrance door and the exit door from the master bedroom on the southwest side of the facility had alarms that were turned to the "off" position.</p> <p>Caregiver #1 admitted on 6/7/10, the alarms were turned off.</p> <p>This was a repeat deficiency from the 1/28/10 State Licensure survey.</p> <p>Severity: 2 Scope: 3</p>	Y 991			

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